BEFORE THE VIRGINIA BOARD OF MEDICINE

IN RE: GREGORY ALAN ALOUF, M.D.
License Number: 0101-230957
Case Number: 191177

ORDER

JURISDICTION AND PROCEDURAL HISTORY

Pursuant to Virginia Code §§ 2.2-4019 and 54.1-2400(10), a Special Conference Committee of the Virginia Board of Medicine ("Board") held an informal conference on September 22, 2021, in Henrico County, Virginia, to inquire into evidence that Gregory Alan Alouf, M.D., may have violated certain laws and regulations governing the practice of medicine in the Commonwealth of Virginia.

Gregory Alan Alouf, M.D., appeared at this proceeding and was represented by Cathy Reynolds, Esquire.

Upon consideration of the evidence, the Committee adopts the following Findings of Fact and Conclusions of Law and issues the Order contained herein.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Gregory Alan Alouf, M.D., was issued License Number 0101-230957 to practice medicine on July 2, 2001, which is scheduled to expire on November 30, 2022.

2. Dr. Alouf violated Virginia Code §§ 54.1-2915(A)(3), (13), and (18) and 18 VAC 85-20-26(C) of the Board's General Regulations, with regard to his post-operative care and treatment of Patient A from approximately February 19 through March 2, 2016, in that contrary to acceptable standards of medical practice, he failed to diagnose, treat, or document adequately Patient A's post-operative wound infection following her in-office liposuction and gluteal fat transfer surgery. Specifically:

a. Patient A informed Dr. Alouf that she had shaking chills and a fever of 100.6 after ibuprofen and Excedrin via a February 26, 2016, text message to him. Although a post-op wound

infection should be presumed at post-operative day 8-10 based on the patient's symptoms, and Dr. Alouf did not document signs or symptoms suggesting any other cause for the patient's fever and shaking chills (e.g. urinary tract infection, pneumonia), he failed to check the patient's White Blood Cell (WBC) count or do an ultrasound to check for a wound infection, and administered Rocephin 1gm IM.

b. Although Patient A informed Dr. Alouf on February 27, 2016, that she still had a fever and did not feel well enough to go to work, he did not examine the patient, document symptoms of any other illness, or check her WBC count, and told the patient that her symptoms were likely due to a virus since the Rocephin "did not work." In sworn testimony, Dr. Alouf stated that he was aware Rocephin could slow the progress of a wound infection, but nonetheless diagnosed Patient A with a viral illness because she was "not going downhill quickly" as he would have expected with a bacterial infection.

c. On February 29, 2016, Patient A texted Dr. Alouf asking for a telephone call because she was "concerned about the fat transfer." Although Dr. Alouf failed to document his telephone call with the patient, in sworn testimony he stated that the patient called because she was having new onset pain and swelling in the lower gluteal areas. Despite the patient's worsening symptoms, and Dr. Alouf's sworn statement that a Complete Blood Count or ultrasound would be the next step if the patient's symptoms worsened, he failed to take steps to determine whether Patient A had a wound infection or advise her to seek treatment at an emergency room or urgent care, and instead prescribed Bactrim "because there was no high fever."

d. Although Dr. Alouf, in sworn testimony, characterized swelling, asymmetry, and changes in skin color as "ominous signs" warranting transfer to an emergency room, he nonetheless diagnosed Patient A with local cellulitis during a March 1, 2016, office visit when she presented with new asymmetrical firmness, erythema, and tenderness over her lower gluteal areas, administered

Rocephin 1gm IM, and sent the patient home with instructions to call if her symptoms worsened.

e. On March 2, 2016, Patient A texted Dr. Alouf that her pain was worse and she was having difficulty urinating and walking due to increased gluteal swelling. During a same-day office visit, Dr. Alouf noted marked increases in swelling, redness, and pain from the previous day. Dr. Alouf performed an in-office ultrasound that revealed multiple abscesses, and he drained approximately 200mls of brown pus from puncture sites in both lower gluteal areas and the right trochanter area. Shortly after the incisions and drainage, while Patient A was still in Dr. Alouf's office, her temperature rose precipitously. Patient A transferred with her partner by private vehicle to the nearest emergency room shortly thereafter.

3. Dr. Alouf violated Virginia Code §§ 54.1-2915(A)(3), (13), (16), and (18) and 18 VAC 85-20-26(C) of the Board's General Regulations with regard to his care and treatment of Patient A from approximately January through March 2016, in that he failed to maintain timely, accurate, and complete medical records. Specifically:

a. Although the intraoperative flow sheet indicates that Patient A complained of pain 5/10 during surgery and that Dr. Alouf treated the pain with a second dose of Stadol (C-IV) 1mg, Dr. Alouf's procedure note states that Patient A was pain free during surgery. In addition, Dr. Alouf's documentation fails to explain the location of the pain and whether the second dose alleviated any of Patient A's pain.

b. Dr. Alouf failed to keep current and accurate medication lists, in that he failed to add Bactrim or Rocephin to the patient's list.

4. Dr. Alouf informed the Committee that on February 26, 2016, Patient A texted him stating that she was not feeling well (i.e., experiencing chills, fever). He stated that he called Patient A right away and advised her to go to urgent care, but Patient A did not want to seek urgent care, as she was a

nurse and did not want anyone to recognize her or know that she had undergone cosmetic surgery. Dr. Alouf stated to the Committee that on this date, he went to see Patient A at her home to check her symptoms and to administer an antibiotic. Dr. Alouf informed the Committee that he took Patient A's pulse and touched her skin for a temperature check. He stated that Patient A's skin felt cool to the touch. In response to the Committee's questioning, Dr. Alouf stated that his differential diagnoses at this time included a normal post-operative course with a low-grade fever from the post-surgical inflammatory process, chills from a viral infection, or a urinary tract infection. Dr. Alouf stated that he administered to Patient A Rocephin IM and informed the patient that he would touch base with her in the morning.

5. The Committee noted that Dr. Alouf failed to bring a stethoscope, blood pressure cuff, or thermometer to the at-home (eight days') post-op visit with Patient A, and that he did not assess or document the patient's blood pressure or temperature reading, respiration, urine output, or bowel movements, nor did he employ other appropriate exam techniques to render a proper diagnosis. When questioned by the Committee as to why he administered a Rocephin injection to a patient who presented with a "normal" post-operative course, Dr. Alouf stated that he administered the antibiotic due to the presence of fever, and because Patient A did not want to go to a higher level of care at that time.

6. The Board's expert, John S. Alspaugh, M.D., opined that the use of the antibiotic (Rocephin) was a confused response by Dr. Alouf, as this would camouflage Patient A's symptoms and allow an infection process to progress and would not be effective for a purulent infection.

7. Dr. Alouf explained to the Committee that on the following day, February 27, 2016, his differential diagnoses were still up in the air as there were many viral illnesses going around at this time of the year. He acknowledged that he did not examine Patient A and stated that he was just watching the follow-up to see how the patient was doing and if her symptoms further progressed. Dr. Alouf reiterated to the Committee that Patient A was very resistant to seek a higher level of care such as urgent

care.

8. The Committee questioned whether it is common to see viral infection in recovering post-surgical patients, and whether antibiotic administration is appropriate to treat a virus. Dr. Alouf responded to the Committee that he "certainly did not abandon the patient." When further questioned by the Committee, Dr. Alouf stated that the most common cause of elevated temperature in a patient six days or more post-op is post-surgical infection. When asked by the Committee why he did not adequately assess Patient A for post-operative infection at this time, Dr. Alouf responded, "In a perfect world we put everyone into a CT scanner, etc."

9. Dr. Alspaugh opined that the burden is on the surgeon to see the patient as quickly as possible to make a diagnosis; to see and examine the patient in-person rather than communicate via texts; and noted that the surgeon must assume that a patient's post-surgical illness has something to do with the procedure that the surgeon performed.

10. Dr. Alouf stated to the Committee that on February 29, 2016, the date on which Patient A texted requesting a return phone call to address her concerns about worsening symptoms and "the fat transfer," he advised the patient to get checked out at the hospital, as it was a Sunday night. Dr. Alouf stated to the Committee that his "hands were tied," as Patient A did not want to go to the hospital ER or to any medical center in the Roanoke Valley. Dr. Alouf stated that Patient A was concerned that, being a nurse, people would recognize her, and she did not want anyone to know that she had had a cosmetic procedure. He stated that Patient A's aversion to going to a hospital made further treatment very difficult.

11. On questioning by the Committee, Dr. Alspaugh opined that when dealing with a difficult patient reluctant to seek a higher level of care, the physician must inform the patient that she needs to go the ER and if the patient refuses, must document the refusal as against medical advice.

12. Dr. Alouf stated to the Committee that the next day, March 1, 2016, when Patient A

presented to his office, she appeared improved and felt better. Dr. Alouf stated that he felt he covered Patient A with good antibiotics for the symptoms she had. Dr. Alouf stated to the Committee that an antibiotic (gentamicin) had been added to the initial fat transfer, noting that this antibiotic lasts 24 – 48 hours, staves off some bacteria, and that an abscess would have been "walled off." Dr. Alouf further stated to the Committee that he felt that at this visit, the less invasive approach was more adequate, as Patient A's symptomatology on this date mimicked a typical post-op fat transfer visit.

13. Dr. Alspaugh noted that transferred fat is a devitalized human product that has no blood supply and cannot defend itself from infection. Dr. Alspaugh stated that Patient A's failure to show a lot of improvement on March 1, 2016, as stated in the medical record, indicated that ultrasound would have been most fruitful, and the best course of action would require surgical drainage.

14. Dr. Alouf informed the Committee that the following day, March 2, 2016, he worked Patient A in for an appointment, at which time he noted that her clinical presentation had changed and recognized that she had an abscess.

15. Dr. Alspaugh opined that Patient A's abscess did not appear within 24 hours, but had been evolving over the course of several days.

16. Dr. Alouf stated to the Committee that while Patient A's pain was not documented in his procedure note, the pre-surgical oral sedation administered to Patient A left areas of pain and discomfort, especially with the use of tumescent anesthesia. He further stated that "the pain was where I was doing the work," and that this was "pretty-much inferred," so there was no need to specify the pain areas in his medical documentation. Dr. Alouf explained to the Committee that patients in his practice are asked post-surgical questions regarding pain and other issues, and that the patients' answers are documented at that time. Consequently, the record in this case would reflect Patient A's answer saying no pain. Dr. Alouf stated to the Committee that he works on trying to improve his recordkeeping and believes that

his records are better than most. Dr. Alouf stated that no one's records are perfect, and that if physicians spent time documenting everything correctly, "we wouldn't be able to practice medicine."

17. Dr. Alouf informed the Committee that the electronic medical record system does not automatically populate medications in the patient medication list. Dr. Alouf further stated to the Committee that while his medication list for Patient A did not show Rocephin and Bactrim, other records show that he administered Rocephin to and prescribed Bactrim for Patient A. Dr. Alouf stated that this information may have been added in later.

18. When asked by the Committee if, in retrospect, he would do anything differently regarding his care and treatment of Patient A in this instance, Dr. Alouf stated, "I don't think I would have changed anything. I don't want to change my practice for one red herring…" i.e., practice defensive medicine. Dr. Alouf further stated to the Committee that in hindsight, one has more clarity, but during the actual course of treatment dealing with the waxing and waning of the patient's symptoms, the ultimate goal is to do no harm and do the best you can, especially with a difficult patient such as Patient A.

19. The Committee noted Dr. Alouf's submission of numerous medical training and continuing medical education ("CME") certificates.

20. In addition to Dr. Alspaugh, the Committee heard from two experts, Gregory N. Laurence, M.D. (licensed in Tennessee, currently on probationary status), and James N. Shearer, M.D. (licensed in North Carolina), who spoke on behalf of Dr. Alouf.

ORDER

Based on the foregoing Findings of Fact and Conclusions of Law, the Virginia Board of Medicine hereby ORDERS as follows:

1. Gregory Alan Alouf, M.D., is REPRIMANDED.

2. Dr. Alouf is placed on PROBATION subject to the following terms and conditions:

a. Within 12 months of the date of entry of this Order, Dr. Alouf shall provide written proof satisfactory to the Board of successful completion of Board-approved courses of at least 10 continuing medical education ("CME") credit hours each (for a total of 40 CME hours) in the subjects of:

i. perioperative care;
ii. surgical complications;
iii. therapeutic use of antibiotics; and
iv. medical recordkeeping.

The course(s) shall be approved in advance of registration by the Executive Director of the Board. Requests for approval must be received at least 15 business days prior to the course date. All continuing education hours/courses shall be completed through face-to-face, interactive sessions (i.e., no home study, journal, or Internet courses). Continuing education obtained through compliance with this term shall not be used toward licensure renewal.

b. Upon receipt of evidence that Dr. Alouf has complied with the foregoing terms of this Order, the Executive Director is authorized to terminate the probation and close this matter, or refer it to a special conference committee for review.

3. Any violation of the foregoing terms and conditions of this Order or any statute or regulation governing the practice of medicine shall constitute grounds for further disciplinary action.

Pursuant to Virginia Code §§ 2.2-4023 and 54.1-2400.2, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

FOR THE BOARD

Jennifer Deschenes, J.D., M.S.
Deputy Executive Director
Virginia Board of Medicine

ENTERED AND MAILED: 10/21/2021

NOTICE OF RIGHT TO APPEAL

Pursuant to Virginia Code § 54.1-2400(10), Dr. Alouf may, not later than 5:00 p.m., on December 1, 2021, notify William L. Harp, Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that he desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated. This Order shall become final on December 1, 2021, unless a request for a formal administrative hearing is received as described above.